



**SUPPLEMENTAL APPLICATION
FOR PROFESSIONAL LIABILITY INSURANCE
PHYSICIANS AND SURGEONS
CLAIMS-MADE COVERAGE
URGENT CARE CENTER**

This supplemental application should be completed for your Urgent Care Center practice only, unless otherwise indicated.

Instructions to the Applicant.

- A. Please answer **all** the questions on this supplemental application(s). The information is required to make an underwriting and pricing evaluation. Your answers hereunder are considered legally material to that evaluation.
- B. If a question is not applicable, state "N/A". If more space is required to answer a question, continue on your letterhead.
- C. This supplemental application must be signed and dated by you.
- D. A General Application must accompany this supplemental application.

I. GENERAL INFORMATION

1. Applicant's Name: _____		Social Security No. _____		
2. Urgent Care Facility: <i>(If more than one location, list on additional sheet)</i>		Number of years practicing at this location: _____	Fed Tax ID: _____	
Street Address: _____	City: _____	County: _____	State: _____	Zip: _____
3. Provide a list of all owners including their percentage of ownership:				
Name		% Ownership		
_____		_____	%	
_____		_____	%	
_____		_____	%	
<i>Must total 100%</i>				

II. URGENT CARE FACILITY OPERATIONS

1. Hours of operation: _____ How many shifts are maintained? _____		
2. Number of Weekly Visits: _____		
3. Please state sources and amounts of annual revenues:		
	Current	Projected
Medicare/Medicaid	_____	_____
Fee for Service	_____	_____
HMO/PPO/POS	_____	_____
Other	_____	_____

III. STAFF

1. Please provide the following information on any physicians providing professional services at your facility:

Physician Name	Specialty	Employee or Contractor?	# Hours/Week	Current Insurance Carrier*	Policy Effective Dates	Limits of Liability
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____

* Please provide evidence of insurance.

2. Identify the number of other employed health care professionals providing services at the applicant's facility:

Type of Professional	# Full Time Employees	# Part Time Employees	# Full Time Contractors	# Part Time Contractors	Contractors Annual Hours
Medical Assistant	_____	_____	_____	_____	_____
Nurse	_____	_____	_____	_____	_____
Nurses Aid	_____	_____	_____	_____	_____
Nurse Practitioner	_____	_____	_____	_____	_____
Occupational Therapist	_____	_____	_____	_____	_____
Phlebotomist	_____	_____	_____	_____	_____
Physical Therapist	_____	_____	_____	_____	_____
Physician Assistant	_____	_____	_____	_____	_____
Radiation Technician	_____	_____	_____	_____	_____
Respiratory Therapist	_____	_____	_____	_____	_____
Other _____	_____	_____	_____	_____	_____

PLEASE PROVIDE ADDITIONAL COMMENTS THAT WOULD FURTHER CLARIFY THE INFORMATION ABOVE OR ADDRESS CHARACTERISTICS OF YOUR FACILITY NOT SPECIFICALLY ADDRESSED HEREIN.

IV. ACKNOWLEDGEMENTS, AUTHORIZATION AND SIGNATURE

I understand the information submitted herein becomes a part of my General Star Insurance Application and is subject to the same warranty and conditions.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act.

Signature of Applicant Print or Type Name Date (month-day-year)